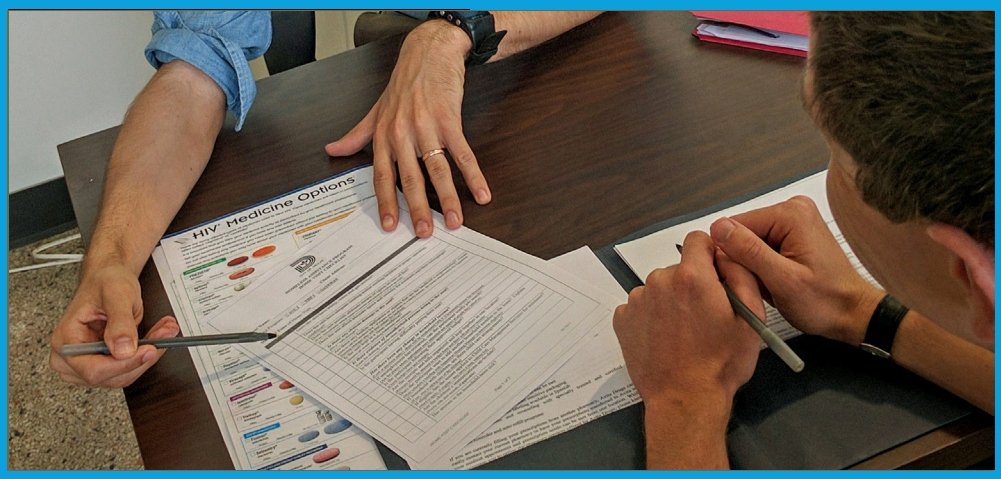

Health, Hope and Recovery

A project of Prism Health North Texas (formerly known as AIDS Arms, Inc.) - Dallas, Texas

Intensive care coordination to link and retain HIV-positive individuals with multiple diagnoses of mental health and/or substance use disorders who are homeless in a medical home

ACKNOWLEDGMENTS

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HEALTH, HOPE AND RECOVERY (HHR) AT A GLANCE

Prism Health North Texas (formerly known as AIDS Arms, Inc.) Dallas, TX

Geographic description: Dallas metropolitan area

Main challenges: Dallas is one of 12 cities in the U.S. representing the largest share of people living with AIDS. People living with HIV/AIDS are more likely, compared to the general population, to have higher rates of homelessness and co-occurring mental health and/or substance use disorders. The importance of improved coordination among service providers in order to reduce treatment delay and discontinuity has been stressed by both stakeholders and consumers.

Focus population: Adults 18 years or older who are HIV-positive with co-occurring mental health and/or substance use disorder(s); homeless, unstably housed or fleeing from domestic violence and who receive or will receive HIV medical care at a Prism Health North Texas clinic.

Description of the model: Intensive care coordination to help navigate the complex system of services including integrated care and treatment for mental health and/or substance use disorders and access to housing.

Medical home model staff: 1.0 FTE care coordinators (3), 1.0 FTE program director, 0.5 FTE case manager

Clients served: 157

Impact: 1) Improved rates of adherence to medical care and viral suppression among HHR participants.
2) Enhanced collaboration with external partners to meet service needs of HHR participants.
3) Strategic expansion of organizational services to better meet the needs of HIV positive clients with multiple diagnoses who are homeless or at risk of homelessness.

ABOUT THE SPNS INITIATIVE

Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations, 2012-2017

People who are experiencing homelessness are disproportionately affected by HIV, and those who are also living with HIV are more likely to delay entering care, have poorer access to HIV care, and are less likely to adhere to antiretroviral therapy. In 2012, the Health Resources & Services Administration (HRSA), HIV/AIDS Bureau through the Special Projects of National Significance (SPNS)* Program funded a national initiative with the goal of building a medical home for a vastly underserved population: those who are experiencing homelessness or unstable housing, living with HIV, and who face challenges of mental health or substance use disorders. Nine clinic and community-based organizations and one multisite coordinating center were funded to implement and evaluate service delivery models for this population. The two main goals of the models were to 1) increase engagement and retention in HIV care and treatment; and 2) improve housing stability. While each model was tailored to the environment in which it existed and the needs of the specific population served, the nine models all created a role of care coordinator/patient navigator who worked with clients to access a networked system of services among HIV, housing, and behavioral health care providers. To measure achievement of project goals, the nine programs conducted a longitudinal multisite evaluation study of the models. For more information about the initiative, visit http://cahpp.org/project/medheart/

Prism Health North Texas was one of the nine demonstration sites funded under this initiative. This manual describes their experience implementing and evaluating the Health, Hope and Recovery model.

*Special Projects of National Significance (SPNS) programs are charged with the development of innovative models of HIV treatment, in order to quickly respond to emerging needs of clients served by Ryan White HIV/AIDS Programs. SPNS advances knowledge and skills in the delivery of health and support services to underserved populations diagnosed with HIV infection. Through demonstration projects such as the one described in this manual, SPNS evaluates the design, implementation utilization, cost, and health-related outcomes of treatment models, while promoting dissemination and replication of successful interventions. Learn more at https://hab.hrsa.gov/about-ryan-white-hivaids-program/part-f-special-projects-national-significance-spns-program

INTRODUCTION

Challenges Faced in Dallas at the Onset

The Dallas Metro Statistical Area which is the focus of the Health, Hope and Recovery (HHR) model includes Dallas County, with a population of about 2.5 million people. When HHR began in 2012, the county was 50.6% female (in 2015: 50.8%) and had a racial distribution of 22.3 % Black, 28.3% Hispanic, and 33.1% White (2015: 23.1%, 39.5%, and 33.1%, respectively). The one-night homeless count in January 2011 identified 5,783 homeless persons in Dallas County. Actual numbers of people who are homeless are probably higher. The table below provides a snapshot of the main challenges related to homelessness and HIV in the Dallas area: a high rate of homelessness, a large number of people living with HIV, and high rates of co-occurring substance use and mental illness.

The Ryan White Comprehensive HIV Services Plan identified gaps in services in Dallas for people living with HIV and a need to improve coordination among organizations providing services. One of the major recommendations of the plan was that improved care coordination was necessary to promote access to services and address treatment delay and discontinuity among those living with HIV. A critical need identified in the county was emergency financial assistance and longer term rental vouchers for people living with HIV/AIDS (PLWHA). Addressing housing needs can facilitate engagement in HIV medical care and treatment which could in turn decrease community viral load and thereby reduce the potential for new infections.

A detailed description of the demographics related to homelessness and HIV, perceived service need, and gaps in care can be found in the *Appendix*.

About Prism Health North Texas (PHNTX)

Prism Health North Texas (PHNTX), formerly known as AIDS Arms, Inc., established in 1986 and designated as a 501(c)(3) nonprofit in 1989, is the largest community-based AIDS service organization in North Texas providing coordinated and comprehensive HIV services focusing on prevention and treatment for HIV and related conditions. The agency's mission is to combat HIV/AIDS in the community by improving the lives and health of individuals living with the disease

Statistics and Demographics of Priority Population - Dashboard Summary

General Population - Dallas County (US Census, 2010)	**Homeless Population – Dallas County** (MDHA, 2011, MDHA 2016)	**People Living with HIV/AIDS (PLWHA) – Dallas County** (DCHHS, 2014)
2.5 million people in Dallas County 51% Female 49% Male 22% Black 38% Hispanic 33% White 7% Other	2011 homeless count 5,783 homeless individuals 2016 homeless count 3,810 homeless individuals 566 chronically homeless individuals - 2011 count	16,146 PLWHA in Dallas County in 2014 887 new HIV/AIDS diagnoses in 2014 Dallas has the second highest number of PLWHA in Texas
Homeless PLWHA (MDHA, 2011)	**PLWHA with Co-occurring Disorders (COD)** (AIDS Arms, 2015)	**Self-Reported Causes for Homelessness** (MDHA, 2011)
40% indicated they had been tested for HIV 6% self-reported an HIV/AIDS diagnosis 19% of Prism Health North Texas clients were in temporary or unstable housing	50% of PHNTX clients screened positive for co-occurring mental health and/or substance use disorders 19% of PHNTX clients received treatment for MH/SU	54% - unemployment/lost job 38% - lack of money 34% - domestic abuse/family problems 30% - substance abuse 30% - mental illness 20% - medical disability
Dallas Area PLWHA Consumer Survey of Overall Identified Service Needs (Ryan White, 2010)	**Dallas Area Identified Service Gaps for PLWHA** (Ryan White, 2010)	**PLWHA Top Reported Reasons for Dropping Out of Care** (Ryan White, 2010)
1) Dental care 2) OB/Gyn (for women) 3) HIV outpatient medical care 4) Food bank 5) Medical case management 6) Medication assistance	1) Long term rental voucher/emergency financial assistance 2) Assisted living facilities 3) Outpatient substance use treatment 4) Transportation 5) Dental care	1) Actively using drugs or relapsed 2) Financial reasons 3) Difficulty keeping appointments 4) Transportation 5) Needed a break

and preventing its spread. This guides our services which a) aim to prevent HIV/viral hepatitis (VH) acquisition and transmission and substance use, through culturally relevant and effective interventions; and b) to identify those who are HIV positive, link them to medical care, behavioral health, and psychosocial support services to improve health outcomes and reduce the risk of transmission. The agency provides outpatient HIV medical care and behavioral health services at two clinics: Oak Cliff (formerly known as Trinity Health and Wellness Center) and South Dallas (formerly known as Peabody Health Center), onsite and mobile case management and outreach, testing and other services. All agency case managers are Affordable Care Act Certified Application Counselors and assist clients with enrollment in the health insurance marketplace.

Jefferson Tower houses Prism Health North Texas' Community and Client Services and Administration.

About Health, Hope and Recovery

While PHNTX has high quality case management services with effective linkage to care and regular referral follow-up, outcome data indicated that an alarmingly low percentage of HIV-positive individuals with co-occurring mental/substance use disorders actually become engaged in treatment, revealing a service system deficiency. This priority population is highly vulnerable, fearful of and often resistant to seeking needed mental health or substance use treatment services, and has difficulty in adhering to or continuing with life-saving HIV/AIDS medical treatment. The complexity and multiplicity of challenges faced by this population require comprehensive services provided within a highly coordinated system of care. The services must address an array of needs: primary care, HIV/AIDS specialty medical care; substance use and mental illness treatment; social support; and income, housing and vocational needs. Drawing upon a framework that utilized behavioral interventions such as strength-based counseling, trauma informed care, cognitive behavioral therapy and motivational interviewing, PHNTX created the Health, Hope and Recovery model to address the multiple, complex needs of this population. A description of the theoretical model and the evidence-based practices the team drew upon to create this program is included in the *Resources* section.

The Changing Landscape

Since Health, Hope and Recovery was introduced in 2012, there have been unanticipated changes in the housing and health care landscape that have impacted HHR and the clients it serves. Here are three of them:

Affordable Care Act (ACA) Rollout

The Affordable Care Act (ACA) was signed into law in 2010 and went into effect with health exchanges needing to be certified and in effect by January 1, 2014. The State of Texas defaulted to the federal exchange and did not expand Medicaid. This left the most challenged clients who had no income or those who did not meet the minimum income requirements with no additional options; they continued to receive HIV care and services funded by the Ryan White CARE Act. Some clients receiving HIV health care and services funded by the Ryan White CARE Act became eligible for ACA health exchange plans, but declined to enroll for financial or personal reasons. Overall, the ACA offered little benefit to clients in the Health, Hope and Recovery program who had no or little income. Some clients who may have benefited from the ACA plans declined to participate if the ACA plans had out-of-pocket costs because they were used to receiving free or lower cost services through Ryan White funded services, despite the additional benefits of ACA plans. Ultimately therefore, the impact of the Affordable Care Act for this priority population was minimal.

Housing First Model in Dallas

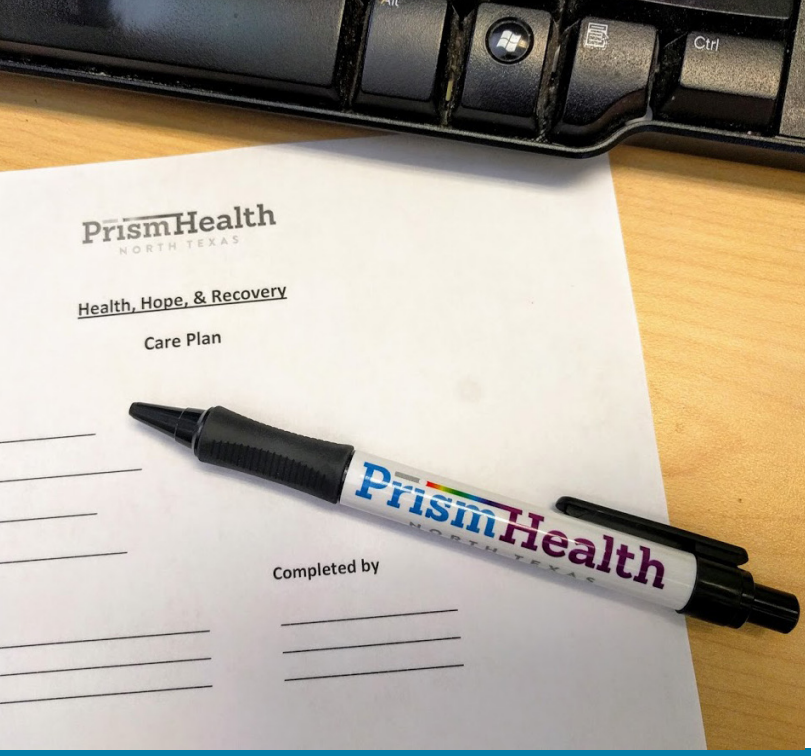
When Health, Hope and Recovery started, the Housing First Model was new to Dallas housing providers. Traditionally people with mental health and substance use disorders were barred from housing unless they were actively addressing the problem. When the Housing First model was implemented and became a requisite to receive funding, it necessitated a fundamental change regarding how housing providers would place clients. Adjusting to the Housing First model was a challenge for many local providers and was initially met with skepticism and resistance. Over the last few years, as housing providers have become more educated about the model and have been able to observe real-life results, Prism Health North Texas staff has noted a change in their attitude toward housing first, thus leading to more support for the model. This has resulted in more housing placements. Behaviors which were previously barriers to placement were no longer considered as such and in fact increased the individual's priority score to qualify for placement.

Continuum of Care Expansion

The Metro Dallas Homeless Alliance (MDHA) has increased its scope with regard to facilitating collaboration among housing providers and related support services for the homeless population (referred to as "continuum of care" for housing purposes as defined by the U.S. Department of Housing and Urban Development [HUD]), in the Dallas area. It has evolved and developed the continuum of care and expanded it to new agencies while strengthening existing partnerships. Programs assisting the homeless population such as Health, Hope and Recovery can vet and refer clients to HUD-funded programs for housing resources even though housing is not the agency's primary mission. Over the past few years, MDHA has assumed greater leadership in the community to facilitate services among agencies. It has developed committees for agency-identified services that need improvement and facilitates and supports those efforts. In addition, it provides educational opportunities/trainings and coordinates the annual homeless census and count and the state of homelessness report for the Dallas area.

The MDHA is also the administrative agency for the Homeless Management Information System (HMIS) and has been instrumental in growing participation among local homeless service providers. In late 2016, Prism Health North Texas began participating in the HMIS which allows staff to more accurately report homeless episodes and services in an accepted database to homeless service providers. Participating in the HMIS has raised the credibility of staff reports and has streamlined the process for placement on the centralized housing priority list.

With the implementation of the Housing First model, MDHA centralized the inventory of HUD-funded housing providers and the criteria for placement was standardized and prioritized through the use of the HMIS enrollment forms and the Vulnerability Index-Service Prioritization and Decision Assistance Tool (VI-SPDAT). These tools provided a uniform assessment of possible services required to assist clients and determine their severity level. Once the needs and severity were determined, clients were assigned a priority number, referred to as DOPS (documentation of priority status), and matched to available housing. This method created a centralized known inventory of housing and a prioritized list of clients across the community of providers. Overall this resulted in quicker housing placements as well as better matching and utilization of housing units to client needs and severity. These changes have had an extremely positive impact on Health, Hope and Recovery staff's ability to get clients into permanent housing.



SETTING UP THE MEDICAL HOME MODEL

Laying the Groundwork

The logic model below was used to develop Health, Hope and Recovery. It provides an overview of the client needs addressed by HHR, the resources that PHNTX drew upon to meet those needs, the activities of the model, and the intended results in terms of output goals and outcomes. This section outlines some of the components needed to set up the medical home model.

Integration of the Model into Prism Health North Texas

Prism Health North Texas has policies that are set by its Board of Directors. The Community and Client Services division within which the Health, Hope and Recovery program resides has some procedures that address all its programs and others which are specific to one program. The procedures are reviewed annually to ensure they are current and relevant. Examples of procedures that apply to all programs are "Maintaining boundaries with clients and other external parties" and "Managing situations in which clients are disruptive/ inappropriate." When new programs such as Health, Hope and Recovery are implemented, specific procedures are developed to help address the specific service categories and program needs. For Health, Hope and Recovery, it quickly became evident that clients often did not have identification documents necessary for enrollment in medical care and other services, and there were no financial resources to obtain them. Therefore when it was agreed that clients would be provided financial assistance to obtain documents, a procedure to support the service was developed. As additional services were added, procedures were developed to support the delivery of those services in order to standardize processes. Pertinent procedures are included in the *Resources* section.

Health, Hope and Recovery is integrated into the comprehensive array of services provided by Prism Health North Texas including outreach, HIV testing and other prevention services such as risk and/or harm reduction counseling and education, outpatient medical care, behavioral health and psychosocial support services which encompass case management (see the organizational chart below). HHR also benefits from the knowledge and expertise of special teams which focus on the previously incarcerated population, Latino/as, women, and youth. The Health, Hope and Recovery team focused on PLWHA who had the most complex

***Health, Hope, Recovery* LOGIC MODEL**

Population Needs	Resources (Inputs)	Program Components/Activities	Outputs	Outcomes
Priority Population Issues & Needs • Disaffiliation • Complex needs • Trauma • Interaction of HIV+, homelessness, COD, poverty • Inadequate life and work skills • Inadequate social capital	**Clients**	**Care Coordination** • Intensive care coordination 12-18 months. • Coordination of medical and other care provided by internal/external sources. • Care intensity based on client acuity. • Tangible reinforcements to assist with adherence to medical care and treatment. • Assistance with transportation. • Assistance with obtaining and storing critical documents. • Emergency assistance with food, clothing, toiletries, and other needs. • Cell phones to help maintain contact. • Assistance with obtaining permanent housing.	**Care Coordination** • 100% have care plans • 100% receive evidence based interventions • 100% receive care coordination • 50% are retained in care	**Care System** • Increased retention in care • Increased adherence to medical treatment • Increased engagement in MI/SA treatment
Client Barriers • Distrust of providers • Aversion to treatment • No transportation • Homelessness • Confidentiality • No payment source • Low income • Substance Use/MI	**Agency Infrastructure** IT, HR, Fiscal, Board, Staff **Project Staff** • Project Director(s) • 3 Care Coordinators • Data Manager • Evaluator **Care and Treatment** • 2 clinics • Medical providers • Onsite behavioral health • Case managers • Co-located pharmacy **Collaboration** • Supportive housing • Transportation • Legal counseling • Vocational services • Emergency, specialty medical & dental care • Shelters	**Medical Home** • Outpatient primary HIV medical care. • Onsite adherence counseling by nurses. • Onsite behavioral health by licensed social workers, psych NP and Psychiatrist. • Onsite risk reduction counseling.	**HIV/AIDS Medical Care** • 100% are in medical care • 100% receive trauma informed care **Social Services** • 100% linked with supports, mainstream benefits • 75% are in supportive housing • 100% linked with needed supportive services **MI/SA Care and Treatment** • 100% receive necessary evidence based intervention to promote engagement • 100% access to appropriate behavioral health care	**Care Coordination Processes** • Care coordination processes and interventions refined • Cost-effectiveness titration established **Client Level** Improvements in: • Housing stability • Mental health • Substance use • HIV related health status • Overall stability
System Barriers • Service silos • Access challenges • Uncoordinated care • Poor treatment integration for HIV and COD • Inadequate MI/SA treatment resources • Inadequate affordable housing options	**Community Support** **Adequate Funding** **Evidence based interventions**	**Collaborators** • Supportive Housing • Emergency/specialty medical care • Dental care • Mental illness/substance abuse treatment • Vocational, legal counseling • Transportation **Linked Services** • Mainstream benefits • Social services and supports **Monitoring, evaluation and feedback.**	**Access to Program Assistance** • 100% receive identified assistance based on assessed need	

The logic model used to develop Health, Hope and Recovery

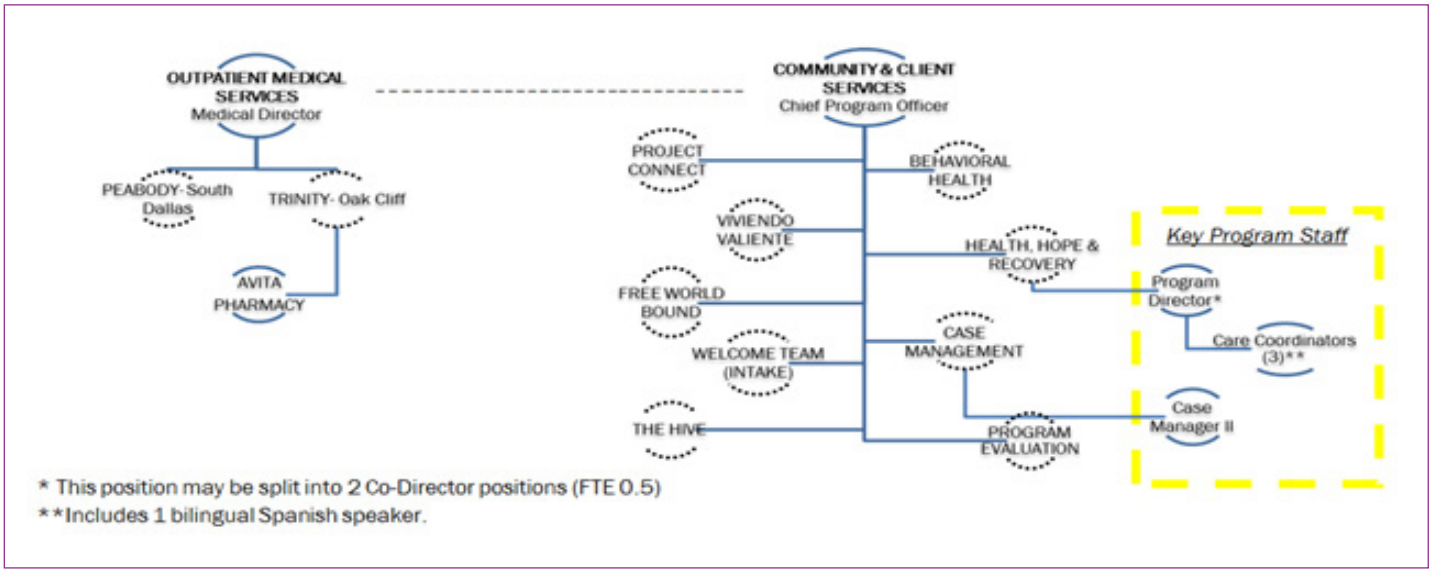
needs related to homelessness, and mental health and/or substance use disorders in addition to living with HIV. The Health, Hope and Recovery team was integrated with the behavioral health and HIV medical team to ensure clients were engaged in HIV medical care as well as psychiatric care and treatment at PHNTX and were able to obtain stable housing with the help of external community partners.

Identifying Internal and External Stakeholders

Client Needs Addressed by Health, Hope and Recovery

In setting up the model, the Health, Hope and Recovery team drew upon Prism Health North Texas' ongoing efforts related to exploring resources available for clients to meet multiple needs (see *Identified Client Needs on pg. 13*), This is an intentional and ongoing process led by the Community Partnerships Director and informed regularly by direct service staff and others. In addition, the agency maintains a searchable electronic Community Resource Database with information on over 1400 unique service providers in the Dallas area.

As a community-based organization that provides comprehensive services focused on the HIV continuum of care and on the complex needs of the client population, PHNTX is able to identify and mobilize necessary services to provide care for Health, Hope and Recovery clients. HHR leverages the collaborative relationships that PHNTX has with multiple stakeholders in the community. These relationships have been formalized through over 100 memoranda of understanding that are updated on a regular basis. Community partners and stakeholders include those within and outside the Ryan White system of care as well as new relationships that are forged on a regular basis. Formal and informal relationships exist with external stakeholders including medical



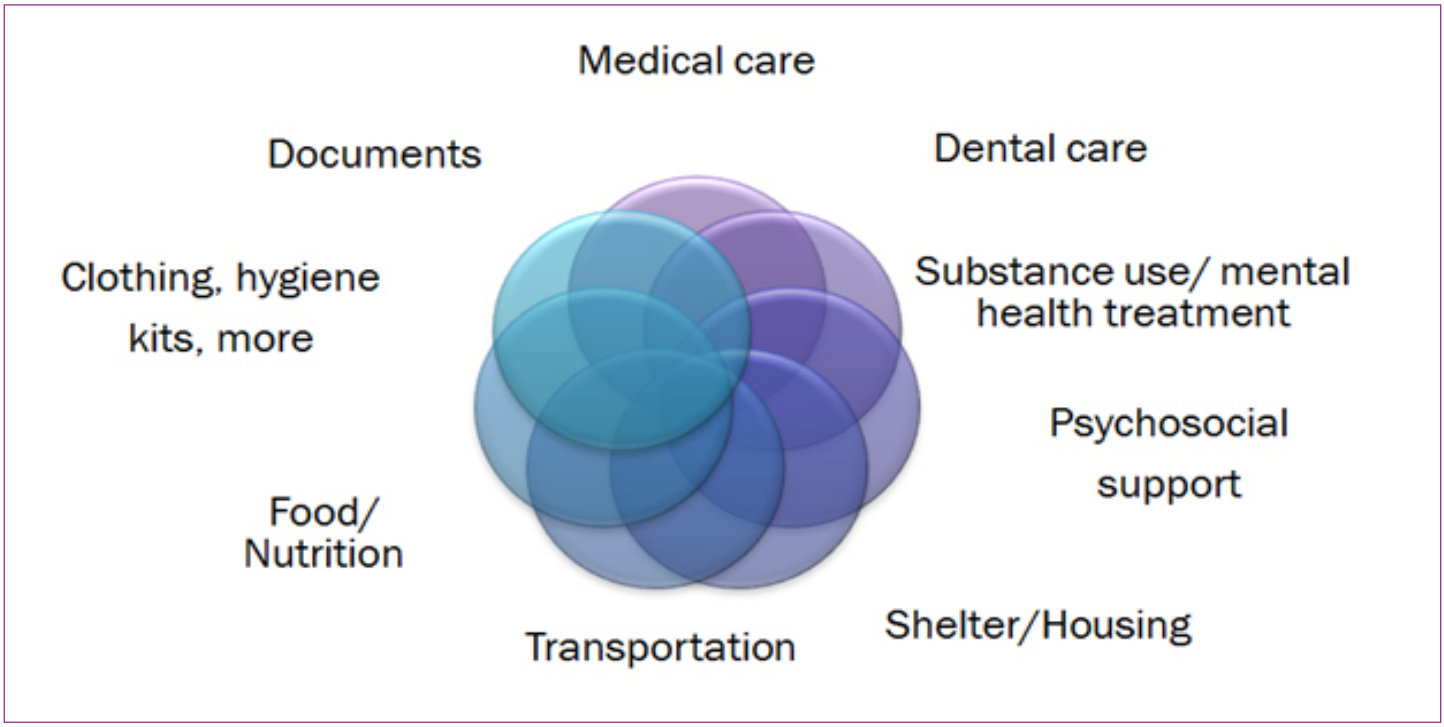
Organizational chart indicating how Health, Hope and Recovery is integrated into the larger organization.

providers, mental health and substance use disorder inpatient and outpatient treatment programs, dental care providers, respite care programs, housing providers and organizations providing varied support services such legal counseling, transportation assistance, and employment assistance. Program staff also plays a role in strengthening relationships specifically with housing service providers such as the City of Dallas, the Master Leasing Housing Program, and housing provided specifically for PLWHA through Ryan White-funded programs. HHR staff worked diligently with the City of Dallas, Shelter Plus Care program to explore opportunities to collaborate and have vouchers assigned for Health, Hope and Recovery clients. This was ultimately implemented through a memorandum of understanding which specified roles and responsibilities of PHNTX medical and behavioral health providers as well as the Health, Hope and Recovery care coordinators.

An invaluable group of stakeholders comprises clients themselves. PHNTX has an active Consumer Advisory Board (CAB) which is also part of the agency's Program Materials Review Panel (PMRP). Health, Hope and Recovery used the PHNTX PMRP to review

> "As we crafted our program, we decided we needed to build the skill set and level of expertise of our staff because this population—being multiply diagnosed with mental health and/or substance use disorders AND being homeless or at risk of homelessness—is one with the most complex needs.
>
> –Staff at Prism Health North Texas

Identified Client Needs by Service Category



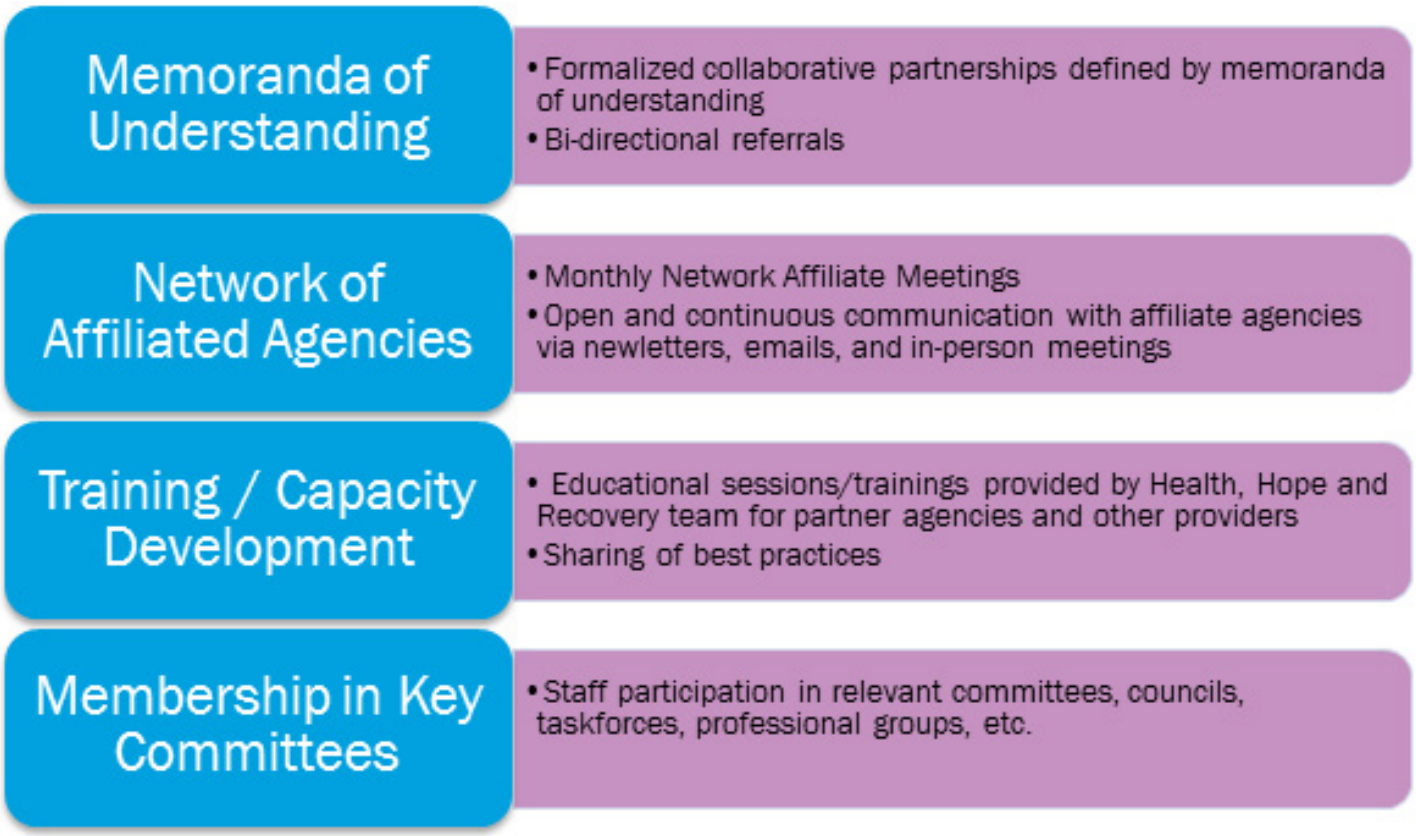
materials when the program was first launched and uses CAB input as needed. For example, the CAB developed a generic Client Satisfaction Survey for the agency which informed the Health, Hope and Recovery client feedback survey that is administered to clients bi-annually. (A link to the client feedback survey is included in the *Resources* section.) In addition, clients are encouraged to consider joining the CAB.

Strategies for Communicating with Stakeholders

Internal stakeholders included all staff that helped support services provided to HHR clients as well the PHNTX leadership team. They were informed about program developments, successes and challenges through regular meetings with specific individuals, groups and all staff. External stakeholders included community partners which served the priority population and were kept informed through group and individual meetings depending on the specific collaborative activity. In several instances, the Health, Hope and Recovery team provided education to internal and external stakeholders on topics such as Trauma Informed Care, the Housing First model, the Role of Emergency Housing and specifics related to serving the priority population.

Finally, PHNTX facilitated monthly meetings with its Network of Affiliated Agencies which included community partners serving PLWHA within and outside of the Ryan White system of care. The purpose of the meetings was to inform stakeholders about new developments related to the HIV continuum of care, new community resources and other relevant topics. Direct service staff and PHNTX leadership served on a variety of committees including the Ryan White Planning Council, Metro Dallas Homeless Alliance (MDHA), the lead agency for coordinating HUD-funded service providers and homeless services in Dallas and Collin counties. These committees met monthly and members voted on issues as needed. The Health, Hope and Recovery program staff periodically attended educational programs offered by the local AIDS Education and Training Centers (AETC) but did not typically collaborate with the centers.

Strategies for Informing and Partnering with Stakeholders



Funding

Health, Hope and Recovery was funded at $300,000 annually. Clients also benefit from the comprehensive array of services provided by multiple other programs supported by other federal, state and local funding sources including Ryan White Parts A, B, C and D as well as the Texas Department of State Health Services (DSHS) which supports behavioral health, risk reduction counseling and an empowerment program for people living with HIV.

Going forward, PHNTX will continue to work with multiple federal, state and local funding entities as well as with donors to help increase funding for key programs, build new initiatives and/or to enhance current programs. Whereas emergency housing (*see* Overview of Services *for additional information on the emergency housing program*) was supported by carryover funds initially, it continues to be sustained by donors who want to support emergency housing for clients in need.

Staff Recruitment and Hiring

Core Staff

Health, Hope and Recovery was initially staffed by a program director full-time equivalent (FTE 1.0) and three care coordinators (FTE 1.0). During year three of program implementation however, to ensure adequate clinical supervision and to cover key administrative functions it was decided to split the program director position to have two individuals at 0 .5 FTE each. Given the severity of substance use and mental health disorders among the priority population, as well as the challenges related to homelessness it was determined that care coordinators would need to have the necessary educational background, skill-set and experience to provide the necessary services.

Requirements for care coordinators are:

- Master's degree in social work or other social service discipline. LMSW, LCSW or LPC with current unrestricted Texas licensure preferred. Education may be substituted by significant job-related experience.

Hiring Process

- A minimum of three years providing Intensive Case Management or Care Coordination.
- A minimum of two years working with the homeless population.
- A minimum of two years working with clients with complex needs including mental health and substance abuse disorders.

In addition to the requirements for the care coordinators, the program director(s) must have a minimum of five years of direct service experience, three years supervisory experience and three years project management experience. The requirements for clinical supervision also include licensure in a relevant field such as social work, professional counseling (see *Job Descriptions* in the *Resources* section for additional detailed requirements for core staff).

Prism Health North Texas staff is diverse and comes from a broad range of ethnic, educational, cultural, linguistic and socioeconomic backgrounds. The staff is 65% racial/ethnic minority (37% African American/Black and 28% Latino); 28% bilingual in Spanish. By reflecting the culture and language of clients, staff can better assist them with unique barriers and needs and more quickly foster rapport and trust essential for client investment in their care. Identification of at least one fluent bilingual Spanish speaking care coordinator is ideal to accommodate clients whose primary spoken language is Spanish. Staff is also able to access interpretation and translation services through the third-party service Language Line when needed. Recruitment for staff is done with great care and by advertising in multiple forums including professional networks.

Recommended Staff

In order to ensure optimal outcomes for the priority population, it is essential to garner the support of a team of experienced medical, behavioral health and housing providers both within the organization as well as in the community. This is key to the intensive care coordination period as well the successful transitioning of Health, Hope and Recovery clients to standard of care. The level of support depends on the acuity level and needs of the client. PHNTX focused on increasing capacity by adding a case manager category (Case Manager II) which requires a higher level of expertise and experience than standard case management, and by providing additional training and education to staff regarding providing services to the priority population. The Case Manager II position has the behavioral intervention background to draw upon if needed and effectively work with clients as they transition to lower acuity and higher level of functioning in standard case management and ideally into self-sufficiency as their needs are met and their situation stabilizes.

Training, Continuing Education, and Supervision

Training and Continuing Education for Care Coordinators

Every care coordinator completes HIV 101 through Texas TRAIN, an online program provided by the Department of State Health Services. Program and other relevant staff involved with clients receive training in motivational enhancement techniques, the Transtheoretical Stages of Change Model, trauma-informed services,

and client engagement techniques. Care coordinators are trained in the Brief Strength-Based Case Management (SBCM) Model for Substance Abuse, Wellness Recovery Action Plan Intervention, Motivational Interviewing, Cognitive Behavioral Therapy, Solutions Focused Therapy, Trauma Informed Care, Harm Reduction Strategies and other strategies to promote engagement and retention in care. (The *Resources* section includes a link to the *Theoretical Model* that outlines the evidence-based practices the program draws upon.)

Training and Continuing Education for all Community and Client Services Staff

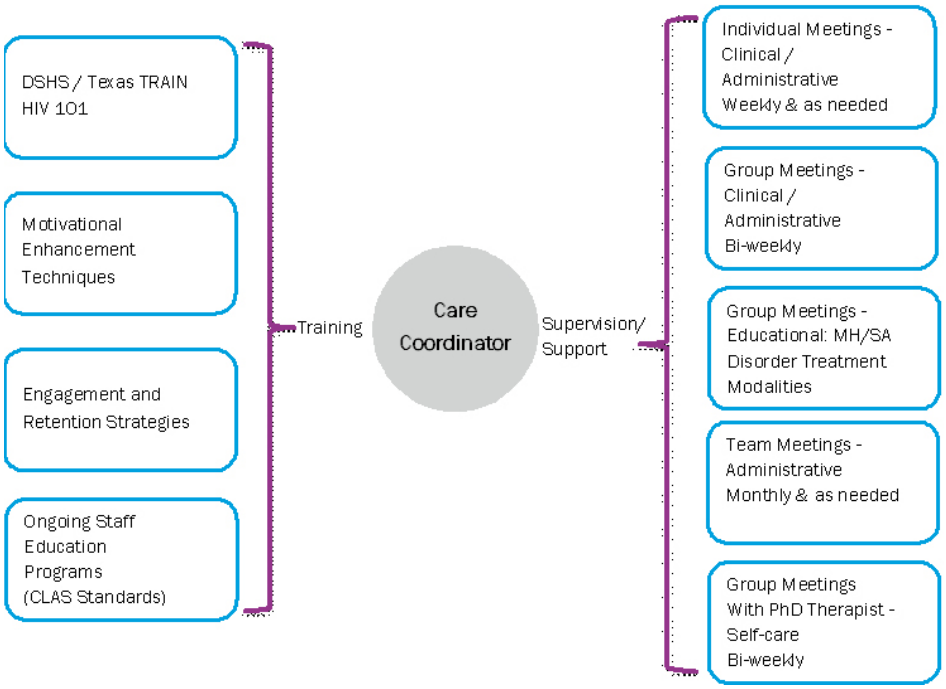
Care coordinators and other staff participate in ongoing educational programs on providing culturally and linguistically appropriate services (CLAS) and following CLAS standards, HIV treatment approaches, and other relevant and necessary topics. Additional educational programs are provided as needs are identified by staff and management. For example, staff has sought out and participated in educational programs on Trauma Informed Care, Addressing Compassion Fatigue and Ensuring Self-Care.

In addition, direct service teams are responsible for developing and delivering programs on best practices related to serving specific populations such as the transgender community, those who are previously incarcerated, the homeless and others. In this vein, the Health, Hope and Recovery team conducted sessions on trauma informed care, what it means to experience homelessness and live in shelters, developing the case to help homeless individuals to be permanently housed as well as other relevant topics.

Supervision

As indicated in the graphic below, supervision for the care coordinators includes clinical and administrative components which are provided both individually and in a group setting. Individually, care coordinators meet bi-weekly with the clinical supervisor to discuss cases and manage challenges. They may also access the supervisor on a walk-in basis to discuss client crises and other problems. Group meetings are also held on a bi-weekly basis. The group meetings include case discussions as well as educational presentations on mental health and substance use disorder treatment modalities. Finally, the care coordinators meet bi-weekly with an experienced Ph.D. level therapist to discuss concerns and to focus on self-care.

Training, Continuing Education and Supervision – Care Coordinators



RECRUITING CLIENTS INTO HHR

Clients are recruited primarily through in-reach; Prism Health North Texas (PHNTX) is a key point of entry for the Dallas area Ryan White system of care and is well-established as an HIV care provider. HIV-positive individuals may be linked to care as a result of referrals from HIV testing service providers, external medical providers and by self-referral.

All individuals seeking care engage in a 'welcome' process which includes a comprehensive intake to: a) assess needs, barriers to medical care, acuity and eligibility; b) initiate the development of a care plan; c) identify key referral needs; d) initiate necessary linkage to case management or another appropriate program including Health, Hope and Recovery based on need and eligibility; and e) make an appointment for HIV medical care at an PHNTX clinic or another provider of choice.

Screening Procedures and Eligibility

All clients, entering medical care at PHNTX are screened at the welcome (intake) appointment for mental health and substance use disorders using the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) tool. (See the *Resources* section for sample materials used). Individuals who screen positive are assessed further for mental health and/or substance use disorders by medical providers, behavioral health counselors, or case managers. Clients who meet the eligibility criteria for Health, Hope and Recovery are referred to the program director who determines if a) the client is eligible for HHR based on stated guidelines; b) whether the client will benefit from HHR; and c) if HHR has availability based on care coordinator caseloads.

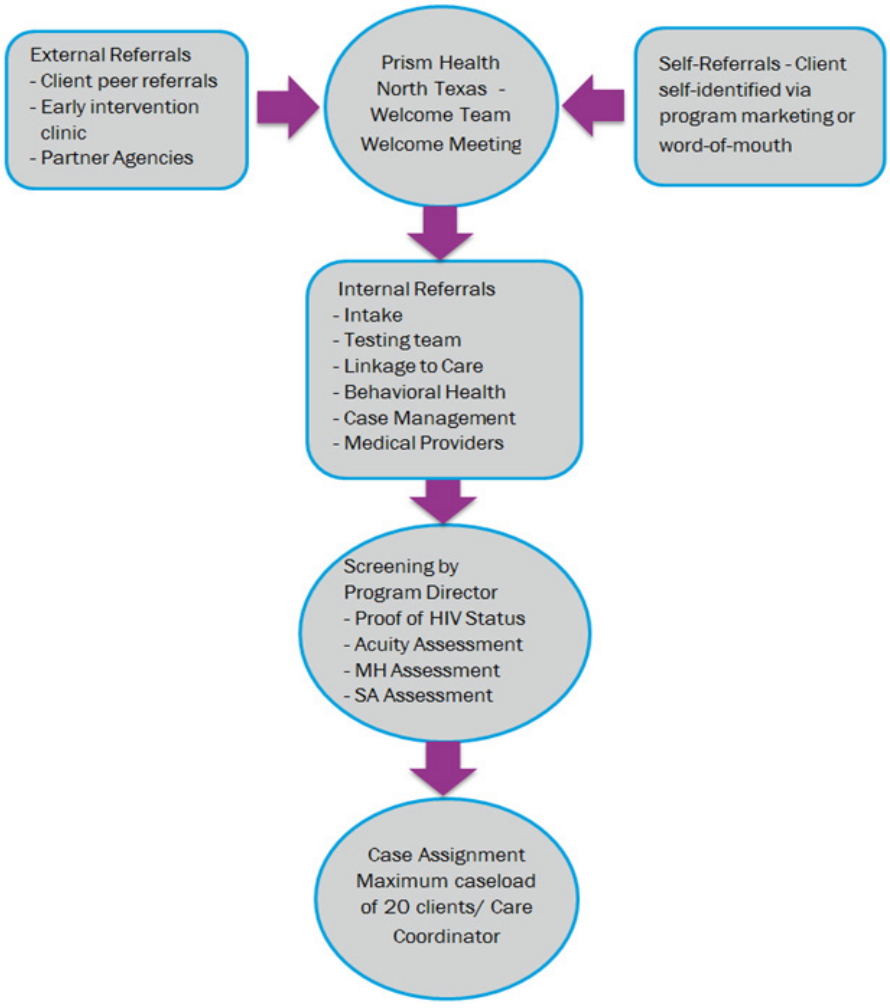
Eligibility for HHR includes the following criteria:

- HIV positive adult 18 years and older with co-occurring mental health and/or substance use disorder(s)
- Literally homeless, unstably housed or fleeing from domestic violence
- Currently receives or will receive HIV medical care at a PHNTX clinic

Referrals (Internal and External) to HHR

As indicated in the diagram below, Health, Hope and Recovery receives client referrals from both internal and external sources. To ensure the program receives appropriate referrals, staff makes brief presentations to internal and external referral sources detailing the goal of the program, eligibility requirements, and the referral process. A formal announcement is made to internal and external partners when referrals to Health, Hope and Recovery are being accepted; and when caseloads are at capacity, an announcement is made that new referrals will be added to a waitlist until further notice. The PHNTX welcome team, the testing team, case managers, linkage to care specialists, behavioral health counselors or medical providers may make a referral based on the eligibility criteria. Referrals are also received from external partners including the Early Intervention Clinic at Dallas County Health and Human Services, partner agencies, client peer referrals, and client self-referrals. (See the *Resources* section for sample collateral materials.)

Health, Hope and Recovery Referral Sources

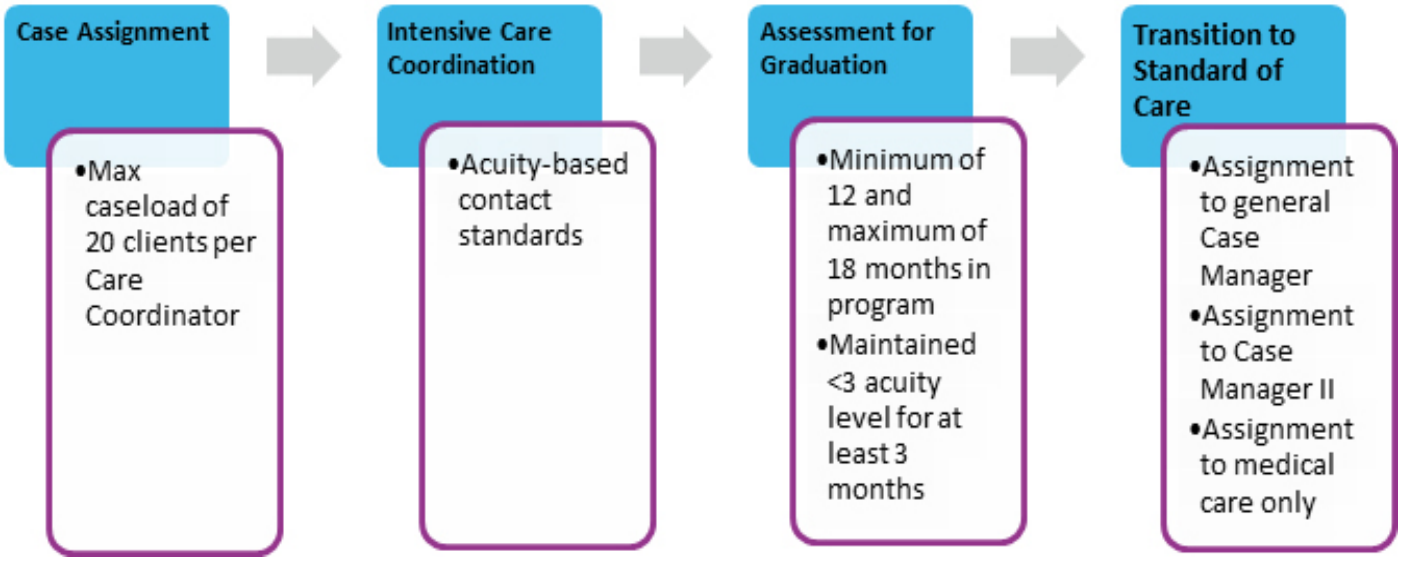


Managing the Flow of Clients

The flowchart on the next page outlines how clients progress through Health, Hope and Recovery. The program director is responsible for screening each referral for eligibility (which includes confirming all Ryan White eligibility documents are available) and assigning cases to the care coordinators. Case assignments are managed by the program director in order to ensure that each care coordinator maintains a balanced case load. Each care coordinator carries a caseload of no more than 20 clients requiring intensive care coordination and a maximum of 5-10 additional clients who are in a maintenance mode. Due to the complexity of a client's needs and the importance of establishing a sound initial base of services, care coordinators are assigned clients gradually and hold the caseload level until clients are graduated. Acuity is assessed upon entry into HHR and at least every 3 months to monitor client progress. (The *Resources* section includes the acuity tool used.)

Health, Hope and Recovery clients face significant barriers to accessing services and have extremely complex needs. This necessitates that care coordinators have more frequent contact with the clients and meet with them wherever they are in order to support engagement, establish rapport, and build trust. The care coordinators work intensively with clients to ensure that they attend their medical, behavioral health and other appointments, achieve their goals and implement behavioral

Simplified Client Flow Chart



interventions. The agency does not assign cell phones to staff and does not allow staff to provide their personal phone numbers to clients. In order to improve access however, Google voice numbers are assigned to care coordinators to allow clients to access their care coordinators through voice or text messages.

Clients become eligible for graduation when they 1) maintain an acuity score of 1 or 2 for at least 3 months, or 2) have received the intervention for a **minimum** of 12 and **no more than** 18 months. When clients are graduated from HHR, they are either transitioned to *standard of care case management* or transitioned to *medical care only* based on decreased acuity and achievement of stability. When the client maintains a lower acuity with consistency, the care coordinator discusses the transition plan with the supervisor. Once the transition is approved, the care coordinator discusses the transition with the client, addresses concerns and implements the transfer through a warm hand-off.

> "Due to the complexity of a client's needs and the importance of establishing a sound initial base of services, care coordinators are assigned clients gradually and hold the caseload level until clients are graduated.
>
> –Staff at Prism Health North Texas

SERVICE DELIVERY MODEL

Overview of Services

The services flowchart below provides an overview of the services available for Health, Hope and Recovery Clients. These include the following:

Orientation: A client entering Health, Hope and Recovery meets with the assigned care coordinator who gives an orientation about what the program is able to provide and articulates care coordinator and client responsibilities. The client reviews and signs necessary consent forms and the care coordinator completes baseline client information and outcome evaluation instruments.

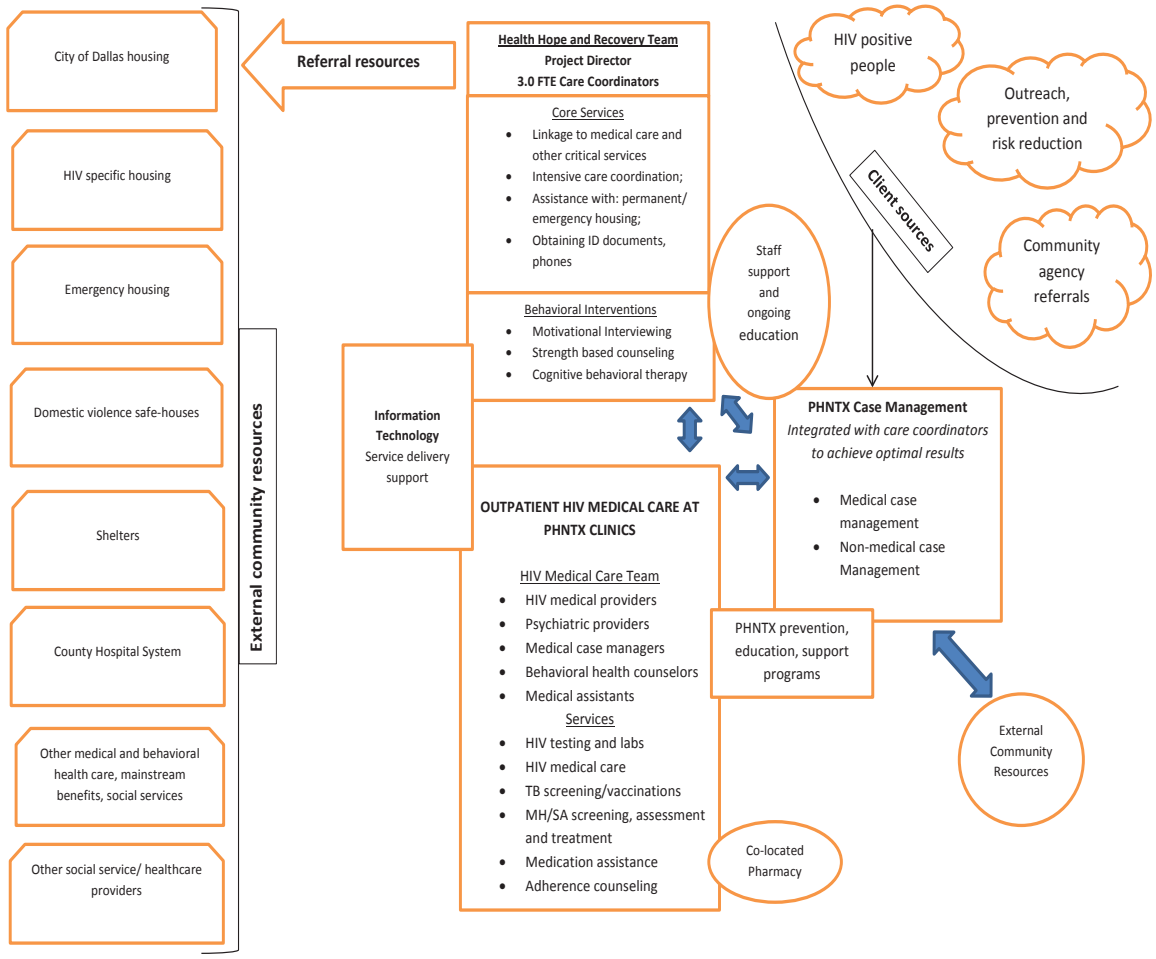
Assessment – In collaboration with the client, the care coordinator conducts a further in-depth assessment to determine care coordination needs by exploring the client's:

- Perception of service needs
- Barriers to care
- Resources for support
- Goals for engagement in care
- Specific care coordination-related requests
- Capacity for trusting, enduring relationships
- Access to phone, email and contact information and additional people with whom the client will allow contact in order to convey messages, in case of need
- Additional concerns and challenges

The assessment by the care coordinator is standardized and uniquely tailored to the needs of the priority population. It provides specific guidance regarding how best to meet clients' care and service needs and assists in the completion of the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPIDAT) which is a key component for helping clients to access housing.

Development of Care Plan – (See *Sample Care Plan* in the *Resources* section) The care coordinator and client work together to develop a **care plan** which may build on the initial care plan that was developed by the client and case manager. It includes the following key elements, which are addressed as the client achieves readiness: (i) medical treatment adherence; (ii) mental health/ substance use treatment; (iii) vocational/ educational needs; (iv) building adequate social supports; (v) housing; (vi) economic sustainability; and (vii) safety/security and addressing the experience of trauma. Motivational interviewing and stages of change concepts guide the

Health, Hope and Recovery Services Flowchart



pace at which the plan is developed and may take more than one meeting. The care coordinator helps the client to identify specific aspects the client is ready to address, join him/her to work on them while clarifying the client's role in the process. The care coordinator and client also develop an agreement for regular meetings and/or telephone contact. The care coordination plan is reviewed and signed by both the client and the care coordinator.

Implementation of the Care Plan – The care coordinator provides the relationship glue that holds the care system together for the client. S/he provides intensive services to keep the client engaged and moves to reengage the client when s/he begins to pull away from treatment or other services. To the extent possible, the care coordinator engages with the client at the pace the client sets, seeking to maintain a trusting, caring relationship and adjusting the plan with the client based on ongoing experience. Key elements of implementing the care coordination plan include:

- Engaging at-risk clients as early in the care process as possible and being proactive in order to maintain client engagement or reengage them.
- Fully utilizing the services of the PHNTX medical team to manage the HIV/AIDS and other medical treatment aspects.
- Working closely with internal and/or external behavioral health staff to help the client engage in and/or be retained in appropriate behavioral health care.
- Providing clients with opportunities for regularly scheduled face-to-face meetings when appropriate.
- Facilitating regular case conferences with relevant providers to discuss and address client challenges and barriers.
- Serving as the primary staff focused on building the "social capital" of the client, including a support network in the community.
- Using evidence-based practices flexibly based on individual client needs.

Key elements of the care plan are included in the PHNTX electronic health record (EHR) so that members of the care team are aware of the client's goals and progress. A link to the care plan is available in the *Resources* section.

Tangible Reinforcements – The care coordinators utilize tangible incentives judiciously to address immediate needs, help keep clients stay engaged and ensure adherence to medical and other necessary appointments. The reinforcements include transportation vouchers, pre-packaged food, backpacks, toiletry kits, blankets, sleeping bags, cell-phones, and food gift cards. HHR also provides financial assistance to help clients to obtain identification documents such as birth certificates and social security cards, and provides a service to store the documents for those who have not yet transitioned to permanent housing. The procedure for providing clients with tangible reinforcements is provided in the *Resources* section.

Emergency Housing – The program provides emergency housing on a temporary basis for clients who are shelter resistant and in an extremely unsafe situation but are well positioned to enter permanent housing. Clients eligible for emergency housing can be accommodated for up to six weeks while the last steps to permanent supportive housing are being finalized. A link to the procedure for providing clients with emergency housing is provided in the *Resources* section.

Acuity Scale – HHR had initially utilized an acuity scale that was adapted from multiple sources by the program director. Unfortunately, this scale was not adequately sensitive to appropriately assess changes in the client's acuity level. Therefore in year 4 of the program, the care coordinators adopted the System Acuity Measurement tool that assesses medical/clinical status, basic necessities/life skills, mental health and psychosocial status, substance/alcohol use, housing/living situation, support systems, insurance benefits, transportation, HIV-related legal needs, cultural/

Weighted Acuity Score	Acuity Level	Recommended Contact
14-16	0	Care coordination not indicated
17-28	1	CC initiated contact bi-annually
29-44	2	CC Initiated contact quarterly
45-60	3	CC initiated monthly contact
61+	4	CC initiated contact every 2 weeks

> "Using the original acuity scale, most of the clients ended up in the "high" category, but that category included a wide variety of challenges and problems without really distinguishing the clients with high needs. This new acuity scale breaks out and weights the areas of housing, mental health, and substance use, so it more accurately captures those more urgent challenges that the client may be facing.
>
> –Staff at Prism Health North Texas

linguistic needs, self-efficacy, HIV education/prevention knowledge, employment/income status, and medication adherence. Scores are weighted and range from 14 to 61+ and align to an acuity level of 0-4 with recommended standards of contact. (The *Transition System Acuity Scale* is available in the *Resources* section).

Working with the Community to Provide Services to Clients

As outlined in the section on *Identifying Stakeholders*, Health, Hope and Recovery staff leverages long-standing partnerships that PHNTX maintains with community partners. For the Health, Hope and Recovery program, some partnerships--particularly those with housing providers--have been strengthened as outlined below:

- PHNTX is a voting member of the Metro Dallas Homeless Alliance
- The formalized partnerships with Shelter Plus Care, Master Leasing Housing program and the Dallas Housing Authority facilitate the process to help clients receive permanent supportive housing regardless of income.
- The City of Dallas Shelter Plus Care program through a formal Memorandum of Understanding (MOU), has agreed to provide 25 vouchers for Health, Hope and Recovery clients in exchange for care coordination and medical services provided by PHNTX.
- Emergency housing at an extended-stay motel for clients that are extremely shelter resistant or have significant barriers to being at a shelter. Barriers include history of assault and victimization in shelters, need for medical respite, and unhealthy environment for people avoiding substance use.

Relationships with collaborative partners are maintained through regular meetings and by being available to support staff of agencies providing services to Health, Hope and Recovery clients in the event that a client is having a crisis and/or needs assistance that is beyond the scope of the service provider. Program staff also attends the monthly meeting of the Network of Affiliated Agencies facilitated by PHNTX that brings together representatives from a variety of organizations which provide

Tom – The Value of Building Housing Relationships

The Health, Hope and Recovery team placed a client in a housing complex and built a relationship with Sue, the property manager. Sue interacted with the team as various issues came up and learned about how the team worked. In the process, she became very supportive of the program. She came to understand the barriers facing clients and appreciated working with care coordinators and case managers before, during and throughout the housing process. Her experiences with clients were positive for the most part, and she housed several additional program clients in her complex, including Tom.

Unfortunately, Tom ended up making choices that compromised his housing, and eventually Sue decided that he needed to be evicted. However as a result of working closely with the care coordinator, she realized that an actual eviction would ruin Tom's chances for finding future housing. As a result of her positive working relationship with staff and her belief in Health, Hope and Recovery's value to the community, she was willing to be of assistance.

Sue agreed that provided he left voluntarily, she would not file an eviction notice or any derogatory reports against Tom. This allowed him to find another housing situation instead of becoming homeless again. This case highlights the importance of building effective relationships with property managers and/or owners so that they become vested in ensuring that clients have positive outcomes and program staff works to ensure that clients are responsible tenants.

multiple services for people in need, including those living with HIV. The goal of the Network meetings is to educate partners about emerging needs of people living with HIV as well as community resources.

Program staff and others seek to build relationships with a variety of providers on an ongoing basis to ensure respectful and appropriate care for clients and decrease barriers. In addition program staff engages in advocacy to promote Housing First, trauma-informed care and other key elements related to providing care for people who are HIV positive, multiply diagnosed and homeless; provides education and technical assistance for community partners regarding best practices; and meets with and informs key influencers regarding the needs of the priority population.

Communicating with Internal and External Stakeholders

In the course of providing services, communication with both internal and external stakeholders occurs through face-to-face meetings, telephone calls and by secure e-mail, and is based on need. In addition, as outlined in the *Strategies for Communicating with Stakeholders* section, the program team implemented a number of mechanisms to make sure that all stakeholders were informed of HHR developments and had a chance to interact with staff. Here are some examples:

- **Organizational Staff Meetings** – Health, Hope and Recovery staff is required to attend the monthly PHNTX all-staff meetings, the bi-monthly Community and Client Services Division meeting and the monthly 'Integrated Services Delivery' meetings. These meetings provide a platform to inform staff about organizational and program developments, challenges and successes, and to provide education about relevant topics. Staff also attends meetings with clinic staff when needed to inform them about developments related to HHR.

Mandy – Transitioning Care Providers

Mandy had been homeless for four years and was able to move into permanent supportive housing after working with a care coordinator for a little over one year. Mandy transitioned from working with a care coordinator to a case manager because she had completed the intensive portion of the intervention that the care coordinator provided.

Mandy, her care coordinator, and case manager conducted several joint meetings and the three of them together developed a new care plan to help Mandy sustain housing long term.

At first Mandy did well in housing, but she allowed some friends who were not stable to spend some time at her apartment. They caused several hundred dollars' worth of property damage for which Mandy was responsible. As a result, she was threatened with eviction by her landlord.

The warm hand-off from the care coordinator to the case manager with Mandy as a key partner was essential to the building of a trusting relationship, which was extremely important during this period. Mandy informed the case manager of her predicament, and the case manager was able to request emergency financial assistance to pay for the necessary repairs. This prevented Mandy from being evicted and again becoming homeless. Mandy was then able to work with her case manager to re-engage in HIV medical care as well as psychiatric care.

- Client encounter notes are documented in the PHNTX electronic health record (EHR) which was switched to Centricity in 2015-16. (See the documentation section below). The notes are available to PHNTX medical and behavioral health providers. A standard encounter note and encounter log was developed to standardize the documentation of encounter content and dosage of program services.

Documentation

Program activities are documented using several mechanisms described below:

Electronic Health Record

PHNTX uses an integrated electronic health record (EHR), Centricity, to capture encounter documentation reported by care coordinators, case managers, behavioral health counselors, and clinicians. Items recorded in this system include acuity assessments, substance abuse and mental health screenings, encounter notes (encounter content), encounter logs (dosage), patient diagnoses, laboratory test results, and medications.

As a Ryan White service provider, PHNTX also reports client services and referrals into the state-wide database, ARIES (AIDS Regional Information and Evaluation System). Clients are able to opt in to sharing their personal data across state providers. In the case that a client has opted in to shared data, providers at PHNTX are able to view Ryan White services accessed at external agencies in the state of Texas.

Case Notes

Care coordinators enter case notes within 72 hours of an encounter. Encounter notes detail the use of the various strategies/ methods (i.e., cognitive behavioral therapy, strength-based case management, solution-focused therapy, motivational interviewing, harm reduction and acuity-based standards of contact).

John – Meeting at the Gas Station

John had completed a lengthy surgery at a major academic medical center that involved a long recovery period and required extensive outpatient follow-up. John was homeless before the surgery and was officially discharged to a shelter, but he did not go to it because he had been assaulted at the shelter before, and no longer stayed at any homeless shelters. He used the bus pass that the hospital staff had given for him to attend his outpatient medical appointment to ride the trains all night, as a form of shelter, and now had no transportation resources. The hospital had also lost John's cell phone.

Fortunately, John was able to call his care coordinator from a land line phone at a gas station to notify him about his situation. The care coordinator met with John in the parking lot of the gas station. The care coordinator and John created a plan for moving forward. The care coordinator provided a cell phone for John to use to get in touch with his outpatient provider and call 911 if he was in a medical emergency. John also received a bus pass from his care coordinator to attend his vital outpatient follow-up appointment.

John and his care coordinator completed the process to obtain permanent housing, and his care coordinator accompanied John to several housing appointments. When John progressed to an appropriate point in the housing process, the care coordinator placed him in a motel through the PHNTX emergency housing program. The care coordinator and John had several meetings at the motel, where John continued to recover from the surgery and was able to complete the follow up appointments for his surgery and HIV medical care. He then progressed into permanent housing.

Documentation standards are monitored by the program director and through the peer review process.

Other Documentation

Additional data collection tools/ documentation are detailed in the *Evaluation and Quality Improvement* section.

Transitioning to Standard Care

The role of the care coordinator is to empower and help the client assume increasing responsibility for his/her own life and develop the competencies necessary to resolve difficulties that emerge with regard to managing physical and mental health and maintaining stability. The Health, Hope and Recovery service delivery plan is built on the assumption that approximately 12-18 months of active care coordination services will be provided to each client. Acuity levels are assessed every three months and guide a decrease in intensity of care coordination services. Clients graduate when they a) achieve a lower acuity level that is maintained; b) decrease their contact with their care coordinator on their own; or c) have received care coordination services for an 18-month duration even though acuity has not decreased.

In all cases, the care coordinator develops a discharge plan which summarizes the client's presenting concerns and current status. Depending on need and acuity level, the client may be assigned to being in medical care only or assigned to a non-medical case manager (standard of care) for ongoing psychosocial support. In each case, to the extent possible the transfer is achieved through a 'warm-hand off'. In some instances, the client, care coordinator and the assigned case manager will meet two to three times prior to the transfer being actualized. Similarly, clients who will receive medical care only go through a phased process to graduation.

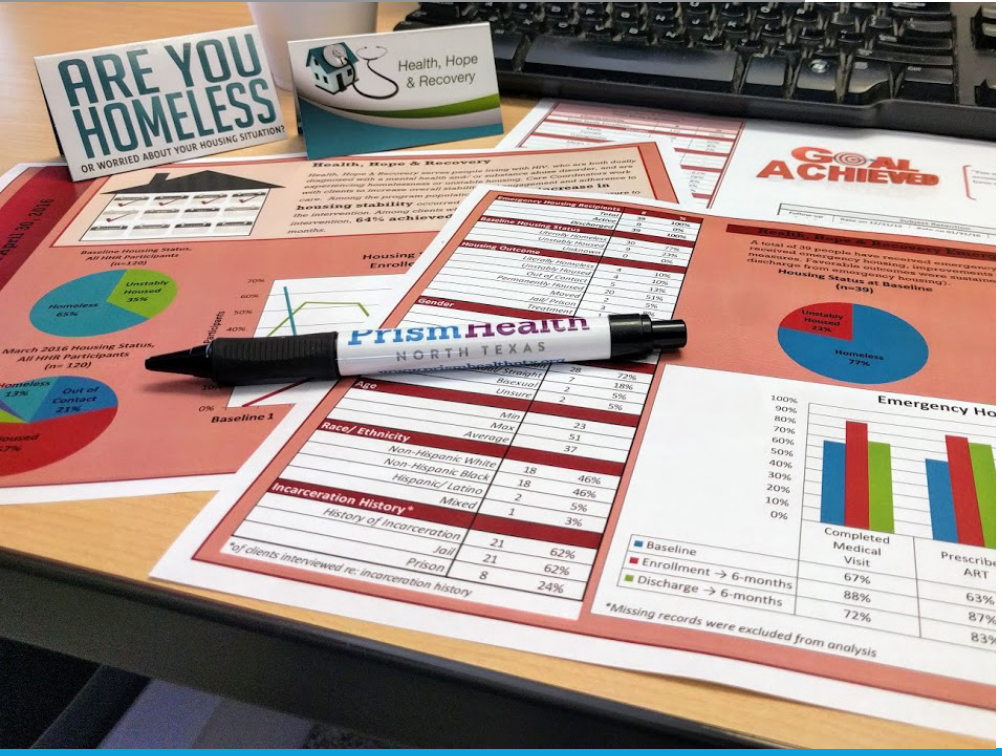
Steven – Meeting at Encampments

Steven suffered from paranoia, was using methamphetamines, and struggled to complete referrals for needed resources such as getting bus passes and HIV medical care, due to lack of trust and because of the impact of his substance usage. The care coordinator was able to meet with him at the homeless encampment that he was living in, and was able to start building trust with Steven. When the care coordinator came to where Steven was at, he brought food and hygiene supplies which improved the quality of Steven's life.

Steven was facing an important appointment that he needed to complete in order to obtain Social Security Disability benefits. After several meetings in Steven's homeless encampment, where the care coordinator worked with Steven regarding how to achieve his goals, Steven agreed to go to the appointment with Social Security.

On the day of the appointment the care coordinator met Steven first thing in the morning to provide a bus pass for him to get to the Social Security office for the interview. He then met Steven later in the day at that appointment and was able to help him manage his paranoid symptoms during the long wait for the interview, thus helping him to complete the appointment.

The pattern of the care coordinator meeting Steven at his homeless encampment and at appointments helped Steven develop trust, complete HIV medical appointments, and follow up with additional necessary referrals that helped him become more self-sufficient.



QUALITY IMPROVEMENT AND EVALUATION

Quality Assurance Plan

PDSA Cycle

The Quailty Assurance (QA) Plan for the Health, Hope and Recovery program utilizes the PDSA Cycle -Plan, Do, Study, Act- to ensure continuous improvement and ensure quality. All quality assurance activities are conducted either monthly, quarterly, or on an ongoing basis. A PDSA cycle was developed for the following program activities and strategies:

- Motivational Interviewing (MI)
- Acuity-based Standards of Contact
- Cognitive Behavioral Therapy (CBT)
- Solution Focused Therapy (SFT)
- Strength-Based Case Management (SBCM)
- Client-Centered Care Plan Development

The table below outlines how the QA plan is developed based on specific program activities and strategies, and its implementation through the PDSA cycle

Supervisor Review & Peer Review

Supervisor reviews are standardized through the use of the *MI Supervisor Rating Form*. Observations are scheduled on a quarterly basis and are conducted during a regular client encounter so that the supervisor can observe the staff persons practical application of MI techniques.

Peer reviews are standardized through the use of the *Peer Review Checklist*. Each care coordinator/ case manager is randomly assigned 4 of their peers' client records to review, on a quarterly basis. Feedback is anonymous and findings are neither punitive nor are they used as documentation for staff performance reviews.

Impact

Implementation of the QA plan formalizes the feedback loop for program staff. Individual discussions are conducted on an ongoing basis; supervision-facilitated group discussions are conducted on a quarterly basis. By completing the PDSA cycle, the team is able to identify training priorities, identify staff support needs, and engage in knowledge transfer on an ongoing basis.

Findings from QA activities are used to facilitate individual and group discussions related to program implementation and strategy development and enhancement.

Evaluation Plan

The evaluation plan for Health, Hope and Recovery outlines measures for monitoring and evaluation of both outcomes and processes. The evaluation of clients'

Quality Assurance Plan for the Health, Hope and Recovery

ACTIVITY	PLAN	DO	STUDY	ACT
Motivational Interviewing (MI)	• Utilize MI Supervisor Rating Form as a standard assessment of use of MI techniques.	• Complete supervisor observation on a quarterly basis. • Record observations in MI Supervisor Rating Form.	• Discuss observations during supervision with care coordinator. • Discuss common observations during team meetings. • Facilitate team discussion on challenges and successes.	• Use commonly cited strengths to establish program-wide best practices. • Use supervisor observation findings to identify training priorities.
Acuity-based Standards of Contact	• Use the HHR Peer Review Checklist as a standard assessment of Acuity-based Standards of Contact.	• Complete quarterly peer review checklist for a random sample of 20% of active clients.	• Team review of aggregate peer review data.	• Use commonly cited strengths to establish program-wide best practices. • Establish new training priorities as needed.
Cognitive Behavioral Therapy (CBT)	• Use the HHR Peer Review Checklist as a standard assessment of CBT.	• Complete quarterly peer review checklist for a random sample of 20% of active clients.	• Team review of aggregate peer review data.	• Use commonly cited strengths to establish program-wide best practices.
Solution Focused Therapy (SFT)	• Use the HHR Peer Review Checklist as a standard assessment of SFT.	• Complete quarterly peer review checklist for a random sample of 20% of active clients.	• Team review of aggregate peer review data.	• Establish new training priorities as needed.
Strength-Based Case Management (SBCM)	• Use the HHR Peer Review Checklist as a standard assessment of SBCM.	• Complete quarterly peer review checklist for a random sample of 20% of active clients.	• Team review of aggregate peer review data.	• Use commonly cited strengths to establish program-wide best practices.
Client-Centered Care Plan Development	• Use the HHR Peer Review Checklist and Supervisor Care Plan Review Checklist as a standard assessment of Client-Centered Care Plans.	• Complete quarterly peer review checklist for a random sample of 20% of active clients. • Complete monthly review active clients' care plan.	• Team review of aggregate peer review data. • Discuss observations during supervision with care coordinator.	• Establish new training priorities as needed. • Provide guidance on developing client-centered care plans during on-going supervision.

outcomes includes assessing the impact of intensive housing stability support, the impact of intensive care coordination, and the impact of emergency housing. The evaluation of processes focused on assessing fidelity to and quality of the use of care coordination techniques, mobility of services, client-centered services, and acuity-based standards of contact. The local evaluation plan was implemented through the use of several local data collection tools, as articulated in the tables below.

Measuring the effectiveness of the Health, Hope and Recovery program presented challenges in that some goals were not easily quantifiable. To answer such questions as "Is the client better off now than before HHR?" various criteria are used. For example, in terms of health outcomes, viral suppression can be tracked over time, and doctor visits and behavioral health visits can also be quantified. In terms of housing, "Did the client find housing, and if so, what kind?" is easily answered. Following the client through the term of the program allows tracking to determine if housing is acquired and sustained. Assessments through self-reporting allow quantifying the client's acuity at baseline and continued periodic assessments allow for the same criteria to be measured and assigned an acuity level at different points in time. Below are examples of grouped tools and measures used in the program implementation that have been useful in collecting data, evaluating outcomes and evaluating processes.

DATA COLLECTION TOOLS		
Data Tool	**Data Collection Frequency**	**Responsible Staff**
Housing Tracking Database	Monthly	Care coordinators/ case manager
Encounter Forms	Within 72 hours of encounter, Ongoing	Care coordinators/ case manager
MI Observation Form	Quarterly	Program director
Peer Review Checklists	Quarterly	Care coordinators/ case manager
Staff Survey	As needed	Case manager
Client Feedback Survey	Bi-annually	Program director

See the Resources *section for templates for all of the mentioned data collection tools.*

OUTCOMES EVALUATION			
Program Component	**Operationalization**	**Measures**	**Data Source**
Intensive Housing Stabilization Support	Care coordinator use of MI, CBT, SFT, and goal setting to aid in clients' ability to achieve stable housing.	Housing Status	Housing Tracking Database
Client-centered Intensive Care Coordination	Care coordinator use of acuity-based contact standards and client centered care plans.	Retention in medical care (at least 1 visit during each 6-month period)	EHR
		Viral suppression (<200 copies/mL)	EHR
		Care plan completed every 6 months	EHR
Emergency Housing	Use of emergency housing assistance to stabilize shelter resistant clients.	Housing Status	Housing Tracking Database
		Retention in medical care (at least 1 visit during each 6-month period)	EHR
		Viral suppression (<200 copies/mL)	EHR

PROCESS EVALUATION			
Process Details	**Operationalization**	**Measures**	**Data Source**
Motivational Interviewing (MI) - focusing on stages of change	Use of MI techniques by care coordinators and fidelity to MI principles.	Adherence rating for MI consistent items	Supervisor MI Observation Forms
		Competence rating for MI consistent items	
		Adherence rating for MI inconsistent items	
		Competence rating for MI inconsistent items	
Cognitive Behavioral Therapy (CBT)	Use of CBT techniques by care coordinators and fidelity to CBT principles.	Mean CBT score [1= Inadequate, 5=Very Adequate] (5-items on peer review checklist)	Peer Review Checklist
Harm Reduction	Use of Harm Reduction techniques by care coordinators and fidelity to principles of harm reduction.	Mean % scored "Yes", when applicable (6-items on peer review checklist)	Peer Review Checklist
Solution Focused Therapy (SFT)	Use of SFT techniques by care coordinators to assist clients and fidelity to SFT principles.	Mean overall SFT score [1= Inadequate, 5=Very Adequate] (5-items on peer review checklist)	Peer Review Checklist
Strength-Based Case Management (SBCM)	Use of SBCM techniques by care coordinators to assist clients and fidelity to SBCM principles.	Mean SBCM score [1= Inadequate, 5=Very Adequate] (4-items on peer review checklist)	Peer Review Checklist
Emergency Housing	Use of emergency housing procedure by program staff.	Favorable review of fidelity to emergency housing procedures, by program director.	Supervisor Review of Emergency Housing Application
Acuity driven standards of contact	Compliance with contact standards protocol.	Mean % scored "Yes", when applicable (3-items on peer review checklist)	Peer Review Checklist
Client centered services	Provision of services based on stated client needs. Care coordinators building of rapport.	Overall client satisfaction [Total % of "Strongly Agree" or "Agree Responses"]	Client Feedback Survey
Community based (Care coordinators are mobile)	Care coordinators meet with clients where they are to engage them.	Percentage of client contacts on site and off site.	Encounter Form
		Total % of "Strongly Agree" or "Agree Responses" to Question 1: "*My care coordinator meets me at places that are convenient (easy) to me.*"	Client Feedback Survey
Case assignment/ transitioning	Warm handoff for transitioning clients	Overall Staff Satisfaction [Total % of "Strongly Agree" or "Agree Responses"]	Staff Satisfaction Survey
Program Capacity	Various	Completed educational sessions, trainings, webinars and conferences	Staff Training Logs

IMPACTS OF HEALTH, HOPE AND RECOVERY

Improved rates of adherence to medical care and viral suppression among clients

The Health, Hope and Recovery program served 157 PLWHA diagnosed with mental health and/or substance use disorders who were homeless or at risk of homelessness. These individuals had extremely complex needs and faced significant barriers to getting engaged in care and treatment. The Health, Hope and Recovery model of care was extremely successful in terms of not only engaging these individuals but helping them to achieve successful outcomes related to HIV viral suppression, adherence to treatment and care, and stable housing.

Enhanced collaboration with external partners to meet service needs of clients

Since the inception of Health, Hope and Recovery, partnerships with homeless service providers in the community improved significantly. This was achieved through a deliberate and intentional process that involved building strong relationships, providing education regarding the needs of clients, learning about processes and the needs of housing providers, ongoing dialogue about challenges and potential solutions. These partnerships helped housing providers to better understand the needs of the priority population and the services provided by Prism Health North Texas and also enabled program staff to learn about effective strategies for navigating the housing system and assisting housing providers with placing clients and keeping them housed.

Strategic expansion of organizational services to better meet the needs of PLWHA diagnosed with mental health and/or substance use disorders that are homeless or at risk of homelessness

Whereas Prism Health North Texas had always served PLWHA with mental health and/or substance use disorders who are homeless, the Health, Hope and Recovery program provided the opportunity to learn much more about the resources necessary to meet the overall needs of the population and to optimize outcomes. HHR

helped provide an improved appreciation of the level and caliber of care required, the importance of building effective partnerships with housing providers including property owners and managers, and the need for emergency housing resources. It also provided more effective tools to document homelessness and track and monitor outcomes. The most significant impact is that the agency has incorporated key elements of Health, Hope and Recovery into the case management program by developing a 'Home Again' case management team which will continue to provide intensive care coordination and case management for the priority population. In addition, important components will be continued such as providing emergency housing, documentation assistance, and prepackaged ready-to-eat food.

> "The Health, Hope and Recovery model was successful in not only engaging individuals but helping them to achieve successful outcomes related to HIV suppression, adherence to treatment and care, and stable housing.
>
> –Staff at Prism Health North Texas

RESOURCES

The following resources from the Health, Hope and Recovery (HHR) model can be found on the Center for Advancing Health Policy and Practice website. All resources from the initiative *Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations* can be found on the web at http://cahpp.org/project/medheart/resources

Prism HHR Theoretical Model (docx): outlines the evidence-based practices that helped with development of the model

Staff Recruitment and Hiring - Job Descriptions

- Prism HHR Program Director (docx)
- Prism HHR Care Coordinator (docx)
- Prism HHR Case Manager II (docx)
- All Prism HHR Job Descriptions (docx)

Training and Supervision Tools

- Prism HHR Case Staffing Form (docx): used to guide discussion with supervisor or team members when care coordinator wishes to solicit guidance regarding a client's care.

Recruiting Clients

- Prism HHR Collateral Material – Palm Card and Rack Card (docx): these materials were used to provide information to potential clients about the HHR program
- Prism HHR Intake Referral Form (docx): used to document first encounter with potential client
- Prism HHR Follow-up Screening (docx): used to track attempts to make contact with client after intake and client's status regarding program enrollment
- Prism HHR Transitional System Acuity Scale (docx): used to assess client's acuity in 14 areas of service need
- Prism HHR Sample Charting Tool (docx): used to track client's acuity in areas of service need over time

Providing Services

- Prism HHR Receipt for Tangible Goods Form (docx): used to document client's receipt of things such as bus passes, gift cards, or food items
- Prism HHR Sample Care Plan (docx): used to document and communicate goals jointly agreed upon by care coordinator and client
- Prism HHR Electronic Health Record (EHR) Modules
    - Prism HHR Sample Encounter Log (docx): used to document in the EHR staff encounters with client

    - Prism HHR Sample Encounter Note with Acuity Worksheet (docx): used to document in the EHR staff encounters with client where client acuity was assessed
- Prism HHR Transition: Program Discharge Form (docx): used to document circumstances under which client graduated from or left the program
- Sample Policies and Procedures
    - Prism HHR Program Outline and Protocol (docx): provides guidance for referrals, assignment, contact, waiting lists, and termination and closure.
    - Prism HHR Acceptance, Safeguarding and Distributing Client Mail (docx)
    - Prism HHR Documentation Replacement Assistance (docx)
    - Prism HHR Distribution of Prepaid Cell Phones and Minutes (docx)
    - Prism HHR Financial Assistance for Emergency Housing (docx)
    - Prism HHR Maintaining Boundaries with Clients and Other External Parties (docx)
    - Prism HHR Managing Situations in Which Clients Are Disruptive/Inappropriate (docx)
    - Prism HHR Disruptive Behavior Client Agreement (docx)
    - Prism HHR Client Complaint Procedure (docx)

Evaluation and Quality Assurance Tools

- Prism HHR Sample Dashboard Report (docx): provides quick overview of key statistics and program metrics
- Prism HHR Sample Evaluation Calendar (docx): used for important project dates such as data reviews, evaluation and observation.
- Prism HHR Housing Status Tracking Database (docx): used to track client housing status over time
- Prism HHR Peer Review Checklist (docx): used to assess client encounters with care coordinators
- Prism HHR Motivational Interviewing Supervisor Observation Form (docx): used to assess staff adherence to motivational interviewing best practices
- Prism HHR Client Feedback Survey (docx): used to assess client experience in the HHR program

APPENDIX

Number and Demographics of Priority Population in Detail

Dallas Area Homeless: A total of 3,810 homeless persons were identified in the January 21, 2016 one-night count of homeless persons in the Dallas area, conducted annually (MDHA, 2016). The number of chronically homeless individuals identified was 566. The actual number of homeless and chronically homeless people in Dallas is unquestionably higher because the homeless survey includes only the point-in-time count and only homeless persons that on the given day are interviewed or physically identified in a homeless shelter, treatment facility, or through street and encampment contacts. It is reasonable to assume that the actual number of homeless in Dallas County is at least 25% greater than the homeless count identified in 2016, or 4,763. Among the respondents, 47% indicated they had been homeless for at least one year and 50% had become homeless for the first time. Among the counted homeless adults, 60% were African American, 33% White; and 7% were identified as 'other'. Those identifying as Hispanic/Latino ethnicity accounted for 13% of the population. Males accounted for 49.6% of the 3,810 adults counted. Eighty-nine percent of the homeless were between the ages of 18 and 61; the largest two age groups were 50-61 (40%) and 40-49 (28%), which represents a gradual increase in the average age of the homeless. Among the chronically homeless, 14.9% of the total, 78% were male and 10% Veterans.

Domestic Violence: The domestic violence report of the Texas Department of Public Safety (DPS, 2013), compiling information from all police departments in the county for 2013, shows that Dallas County had 21,419 reported incidents, which is generally considered to be well under the actual number of domestic violence incidents that occur. In the 2016 Dallas County homeless count (MDHA, 2016), 15% of respondents (572 of the estimated total) cited domestic violence when asked to identify reasons why they were homeless and identified themselves as domestic abuse victims.

People Living with HIV/AIDS (PLWHA) in Dallas County: Dallas is one of 12 cities in the U.S. representing the largest share of people living with AIDS and Dallas County has the second highest number of PLWHA in Texas. More importantly, due to improved medical treatment for HIV, PLWHA are living longer and the number of PLWHA continues to increase. In 2014 there were 887 new HIV/AIDS diagnoses and a total of 16,146 PLWHA in Dallas County. Of significant concern is that many individuals receive late diagnoses, i.e. 32% receive an HIV and AIDS diagnosis within one year (DCHHS, 2014).

Homeless PLWHA: Among respondents for the Metro Dallas Homeless Alliance (MDHA) homeless count, 40% indicated that they had been tested for HIV and 6% stated that they were diagnosed with HIV/AIDS. This self-reported percentage is higher than national estimates (3.9%) from a Housing and Urban Development (HUD) assessment (AHAR, 2010). However, a San Francisco study found an HIV prevalence rate of 10.5% among homeless and unstably housed adults (Robertson et al., 2004). Applying the three rates, HUD, the Dallas homeless count, and the San Francisco study, in 2010 there were somewhere between 282 and 759 homeless PLWHA in Dallas County in 2010. In 2015, 19% of Prism Health North Texas clients were in temporary or unstable housing (AIDS Arms, 2015 RSR Report).

PLWHA with Co-Occurring Mental and/or Substance Use Disorders: Based on national statistics related to the incidence of substance use and mental illness among the homeless population and the elevated rates of these disorders among PLWHA, at least 50% of the homeless PLWHA (141 to 379) are estimated to have co-occurring mental and/or substance use (MH/SA) disorders. The number of unstably housed and those fleeing domestic violence without housing resources who are HIV positive and have co-occurring disorders is estimated to be much greater.

Challenge of Engaging PLWHA with Co-occurring Disorders (COD) in MH/SA Treatment: While 50% of Prism Health North Texas (PHNTX) clients screen positive for MH/SA disorders, only 19.3% received treatment MH/SA in 2011. As is typical with HIV/AIDS organizations, the PHNTX service delivery system depends on referral of patients with co-occurring disorders (COD) to external treatment resources. Referral data indicate approximately 60% of these clients do not receive this treatment, lowering HIV treatment adherence rates and increasing care discontinuity. Homeless and PLWHA survey data also reveal that while mental illness and substance use is prominent among these populations, interest in treatment particularly for substance abuse is extremely low. Another significant factor is the underfunded behavioral healthcare services system in Dallas County and elsewhere. A legislative briefing report (Humphrey, 2010) for North Texas behavioral health authorities noted that in 2008 Texas treated only 5.8% of chemically dependent Texans who qualified for state funded services. Thus, even willing clients have difficulty obtaining needed treatment.

Perceived Service Needs

In rank order, the top six self-reported causes for homelessness reported by those served in the Dallas homeless count (MDHA, 2011), were unemployment/lost job (54%), substance abuse (30%), lack of enough money (38%), domestic abuse/family problems (34%), mental illness (30%) and medical disability (20%). When asked to identify benefits or services they needed, only 5% indicated substance abuse treatment and 8% mental health care. The ten most frequently identified needs were 1) bus passes (38%), 2) dental care (33%), 3) job placement (31%), 4) permanent housing (30%), 5) transportation (27%), 6) job training (21%), 7) clothing (21%), 8) food stamps (20%), 9) medical care (20%), and 10) Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI)/ Education Options (16%). The 2010 Comprehensive HIV Health Services Plan (CHHSP) for the Dallas area (Ryan White, 2010) provided the results of a consumer survey identifying the top overall service needs, in rank order. The top five were: 1) dental care (66.3%); 2) OB/Gyn care (for women); 3) HIV outpatient medical care (63.9%); 3) Food bank (59.8%); 4) medical case management; and 5) help paying for medications.

Gaps in Care

The Comprehensive HIV Health Services Plan (Ryan White, 2010) identified the following gaps in services in the Dallas area for PLWHA, 1) long term rental voucher/emergency financial assistance; 2) assisted living facilities; 3) outpatient substance abuse treatment; 4) transportation; and 5) dental care. In the same needs assessment, the top five reasons given by surveyed consumers for dropping out of care for six months or more were: 1) actively using drugs or relapsed (48%); 2) financial reasons (40%); 3) difficulty keeping appointments (33%); 4) transportation (32%) and 5) needed a break (25%).

One of the major goals set forth in the plan was to *improve coordination of effort between organizations.* Implicit in the needs, perceived service needs, and gaps in care analysis was the need for heightened care coordination to improve access to available services for this highly vulnerable population. Treatment delay and treatment discontinuity imperil the health of the client and increase costs.

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